

Citation for published version:

Daniels, J, Osborn, M & Davis, C 2018, 'Better safe than sorry? Frequent attendance in a hospital emergency department: an exploratory study', *British Journal of Pain*, vol. 12, no. 1, 12, pp. 10-19.
<https://doi.org/10.1177/2049463717720635>

DOI:

[10.1177/2049463717720635](https://doi.org/10.1177/2049463717720635)

Publication date:

2018

Document Version

Peer reviewed version

[Link to publication](#)

Jo Daniels, , Mike Osborn, , Cara Davis, 2017. 'Better safe than sorry? Frequent attendance in a hospital emergency department: an exploratory study', *British Journal of Pain*, Vol. 12, no. 1, pp. 10 - 19. Copyright © 2017 The British Pain Society. Reprinted by permission of SAGE Publications.

University of Bath

Alternative formats

If you require this document in an alternative format, please contact:
openaccess@bath.ac.uk

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Abstract

Introduction: Pain accounts for the majority of attendances to the Emergency Department (ED), with insufficient alleviation of symptoms resulting in repeated attendance. People who frequently attend the ED are typically considered to be psychologically and socially vulnerable in addition to experiencing health difficulties. This service development study was commissioned to identify the defining characteristics and unmet needs of frequent attenders in a UK acute district general hospital ED, with a view to developing strategies to meet the needs of this group.

Methods: A mixed methods multi-pronged exploratory approach was used, involving staff interviews, focus groups, business data and case note analysis.

Results: Findings reflect an absence of a coherent approach to meeting the needs of FAs in the ED, especially those experiencing pain. FAs to this ED tend to be vulnerable, complex and report significant worry and anxiety. Elevated anxiety on the part of the patient may be contributing to a 'better safe than sorry' culture within the ED and is reported to bear some influence on the clinical decision-making process.

Discussion: It is recommended that a systemic approach is taken to improve the quality and accessibility of individualised care plans, provision of patient education, psychological care and implementation of policies and procedures. Change on an organisational level is likely to improve working culture, staff satisfaction and staff relationships with this vulnerable group of patients. A structured care pathway and supportive changes are likely to lead to economic benefits. Further research should build on findings to implement and test the efficacy of these interventions.

Keywords

Pain, frequent attendance, emergency department, accident and emergency, psychology

Introduction

Pain is reported to account for up to 78% of attendances at Emergency Departments (ED)¹. Up to 82% of those presenting with pain will leave the ED with moderate to severe levels of pain similar to that reported upon arrival²⁻⁴ however most leave without intervention. It is therefore unsurprising that this statistic includes those who repeatedly attend the ED. The ‘frequent attender’ phenomenon is observed internationally and across differing healthcare systems^{1,5} and is likely to be a key contributing factor to the recent escalating crisis within UK NHS EDs.

Patients who attend the ED frequently (termed ‘frequent attenders’ (FAs) for the purpose of this study) symbolise unmet need: whether the presenting complaint is the same or different, patients who frequently attend the ED bear a significant economic and personal burden due to ongoing symptoms or anxieties being insufficiently alleviated. FAs typically present with a complex, chaotic background and unexplained symptoms or pain⁵ and are considered to be psychologically and socially vulnerable in addition to experiencing health difficulties⁶. FA’s may belong to vulnerable groups, such as the homeless⁷ and are commonly found to be older than non-frequent attenders^{8,9,10}. They are more often male¹⁰, single and of a lower socioeconomic status⁶, and are also likely to present with alcohol- or mental health-related issues⁷. This presents complex clinical challenge within emergency medicine settings; psychosocial factors are likely to influence engagement, communication, assessment of need and treatment.

Decision-making regarding seeking medical help is complex: psychological, social and medical factors are interrelated and cannot be understood purely in terms of health need¹¹: research indicates that there are indeed many psychological factors likely to influence patients’ decisions to access the ED, including understanding of their health condition¹², accessibility of other services¹³, level of distress and influence of others, such as health professionals or families¹⁴⁻¹⁵.

Anxiety appears to be a particularly prominent factor in accessing health care: a number of studies have found anxiety to be considerably influential in the decision to seek medical help and how urgently that help is sought¹⁶⁻¹⁸. In one study, fear resulted in actual avoidance of seeking help as well as help seeking¹⁹. Previous research⁵ identified that FAs often made links between current symptoms and previous trauma, interpreting pain as potentially catastrophic and life-threatening. This caused heightened anxiety which prompted them to seek help, and underlies an expressed need to be respected by health professionals for their decision to do so. It therefore makes sense that where a problem is not solved following help-seeking, there is subsequent increased help-seeking from other sources²⁰, which may inform a cycle of frequent attendance when sufficient reassurance is not gained. Previous

experiences of help-seeking are also likely to influence the decision to seek help in the future, whether this is due to positive outcomes (e.g. experiencing helpful treatment) or negative outcomes (e.g. feeling dismissed)²⁰.

Attending EDs rather than primary care practitioners or other services has been attributed to patients being unaware of alternatives to the ED, particularly outside of GP hours¹³. This is particularly pertinent considering a good relationship between patient and GP may prevent unnecessary or repeated ED attendance¹⁴⁻¹⁵. A recent study suggested that patients with minor health problems and low level pain attend the ED instead of their GP upon the advice of others, and not because the ED is seen as more ‘accessible’¹². The study also identified that FAs had often consulted another healthcare professional beforehand, yet patients attended the ED for a second opinion or reassurance that the problem was not serious in nature¹². This suggests that for some, anxiety and concern may be elevated to the point where they are not reassured even by a long-standing GP, or that there is some level of dissatisfaction on initial health consultation that could be addressed at an earlier point in the common FA pathway through services to the ED.

It is commonly recognised that treatment of pain in the ED is insufficient – both for acute and chronic pain^{2, 21-22}. This of course also applies to FAs who have complex presentations, e.g. long-term physical health conditions, psychological distress, medically unexplained symptoms, or those whose pain cannot be clearly treated through usual medical routes, but who are also unable to obtain reassurance about the cause and meaning of their pain. It has been suggested that a shift towards recognition of the relevance of psycho-social issues in the medical culture may positively influence attitudes towards those with more complex presentations, to ensure they access appropriate pain analgesia and psycho-social intervention (an individualised multi-modal approach including stress and pain management strategies as routine care)²¹⁻²³.

Taking a multi-disciplinary ‘case management’ approach has been shown to significantly decrease FA visits by 31%²⁴ however it is noted that plans need to be reviewed regularly to optimise utility of this intervention²⁵⁻²⁶. Primary Care input^{8, 27} and more homogeneous clinics for urgent care¹² are also advocated. Pillow and colleagues²⁵ recommend an appointed referral system to specific chronic condition clinics to better support the needs of people with long term conditions, who often use the ED and other healthcare services to inefficiently meet their needs^{6,28}. Provision of information and education around health issues for people with chronic illness also yields positive outcomes in minimising unnecessary ED attendance²⁷⁻³⁰.

It is evident that the needs of FAs are complex and varied; a more detailed understanding of the FA and their interaction with the ED is needed to more effectively address patient need, especially in the context of current suboptimal care pathways for pain treatment in the ED.

This exploratory service development study was commissioned to address the following aims:

1. Describe the defining characteristics and unmet need of the ED frequent attender
2. Explore staff perceptions and attitudes towards ED frequent attenders
3. Produce a series of evidence based recommendations designed to meet the needs of frequent attenders to the ED and improve the management of pain within this setting.

Method

The first two aims of the present study were explored separately using mixed methods approaches, including both qualitative interviews and analysis of quantitative business data.

The third aim of developing a series of evidence based recommendations was drawn on the outcomes of aims one and two and presented as part of the discussion.

All aspects of the study took place in an acute district general hospital ED in the South West of England.

1. Describing the defining characteristics and unmet needs of the frequent attender

Four approaches were deemed useful here: a) an opportunistic sampling of ED attenders to gather preliminary data as a baseline; b) analysis of summary business data of the top 50 attenders to describe the FA; c) a more in-depth analysis of the top 10 frequent attenders to capture more rich and complex data to contribute to understanding of what defines the FA; d) review existing care plans to establish whether there are common themes and observe current practices.

a. Emergency department patient interviews

A brief structured interview with patients referred to 'majors' section of the ED was conducted by two clinical psychologists on four evenly spaced occasions over the course of 6 months. Interview questions were informed by the literature and developed iteratively between the ED lead consultant and two clinical psychologists.

Participants and procedure:

Approximately 20-25 patients were approached in the ED and invited to participate in a brief interview. On initial contact, permission was sought to ask six brief clinical questions: reason for

attending/presenting problem; current health problems/concerns; recent history of presenting complaint; trigger for attending the ED rather than self-manage; level of pain at interview (0-10); mood at interview. The interviewer explained in advance that all responses would be recorded verbatim in their clinical notes.

Of those approached, ten patients were recruited . A number of patients declined to engage or were not approached for reasons relating to severity of presenting problem/distress. Demographic information was not available on this sample.

b. Analysis of Business Data

Relevant data from top FAs (N=50) was acquired from the business intelligence department of the NHS trust to produce descriptive analysis of the group as a whole. This included a summary of all hospital related activity (e.g. admissions, outpatient), demographic information and referral path.

Participants:

Participants ranged from 17-90 years of age, with a mean age of 39. Of the 50 top attenders, 48% were female.

c. Case Note Analysis

Case notes for the top 10 FAs were reviewed by two clinical psychologists to identify common themes. Based on ED FA literature, specific evidence was gathered relating to the following factors:

- (i) Physical / mental health problems
- (ii) Medication / polypharmacy
- (iii) Inter-agency involvement
- (iv) Psychosocial problems
- (v) Any other factors deemed relevant

d. Care Plan Review

Five care plans produced for FAs were requested from the ED consultant, however only four were available for review.

2. Exploration of staff perceptions and attitudes

Senior clinicians associated with the ED were invited to participate in a brief 10-15 min semi-structured interview to discuss their views and opinions of FAs. Participants were asked (a) what they considered to be the relevant factors involved in frequent attendance at the ED (b) how these factors could be addressed to reduce frequent attendance. Further probes and clarification questions were asked.

Participants

Specific clinicians were targeted due to their involvement and respective responsibilities along the pathway from ED to pain clinic. The sample (N=8) included two ED nurses, two ED consultants, one specialist nurse from the pain clinic, consultant anaesthetist and two clinical psychologists. Five of the sample were female (63%). Of those approached, 100% agreed to participate.

Results

1. Describing the defining characteristics and unmet need of the frequent attender

a. Emergency Department patient interviews:

Of the patients seen in triage, the ED visit was typically triggered by concerns raised by close family members or GP advice. The exception was GP unavailability, in which case patients reported that NHS Direct /111 directed them to the ED. Patients commonly attended with a prior condition and/or severe pain and assumptions regarding the seriousness of the problem. Patients typically reported contacting their GP if they didn't know what the problem was.

Some patients' family members had suffered similar illnesses which likely influenced decision making around health management: experience inevitably informs patients' views on specific illnesses and symptoms. For example, the mother of a patient with abdominal pain had died following similar symptoms, which led her to take the approach 'better safe than sorry.'

In the majority of patients, pain ratings at the worst point of pain were 7/10 and often higher. Pain ratings were often lower in the days preceding this. Thus, it appears pain had to be severe and consistent to result in ED attendance: there appears to be a threshold breached when 'normal pain' is elevated to perceived status of 'life threatening/very serious pain' which then warrants ED attendance. It was apparent that pain at a level of 7/10 indicated a level of pain that needed intervention.

Worry appeared to be higher at the onset of pain but often reduced by the point of being seen in the ED even if the outcome/diagnosis was unknown, perhaps reflecting a sense of reassurance and relief simply being in the ED ('the best place to be if something goes wrong [sic]'). There was no identifiable relationship between stress in daily life and ED attendance, although this may be related to the older

age of the population triaged. High levels of stress were usually reported by patients with carer responsibilities. This may indicate that ED is a routine part of their lives and deemed an appropriate place to get 'quick' treatment. Alternatively, it may mean that these patients are preoccupied with caring for others to the point that they neglect their own needs and defer help seeking until difficulties are elevated to an urgent level. See appendix 2 for a sample log from the ED triage.

b. Analysis of business data

Demographic data from the top 50 attenders were analysed to identify whether there were any defining characteristics of this group, or whether they were broadly homogenous.

Over the course of a 12 month period, the top 50 attenders averaged at 17.7 attendances which averaged at around just over once per month. Of these 884 attendances, 48.9% were admitted with approximately 60% being discharged within 48 hours. Those who were admitted were usually discharged without diagnostic or medical procedures being performed (81.6%).

The lack of diagnostic procedures indicates that patients may be admitted due to potential 'breach' of ED waiting times, with a degree of certainty on the part of the medical team that the presenting symptoms are not life-threatening or indicating a medical emergency.

In terms of the demographics of this group, the most frequent attenders fell within the 36-40 and 21-25 year age group, with least attendance in the 66 years and over category. The split between males and females is relatively equal, with males presenting as the most frequent attenders by a small margin (52%).

Attendance elevates slightly throughout the week with a peak on Friday (18% of attendance by FAs) the remainder falling relatively evenly across the week (12.4-14.7%). The most common time for this group to attend is between 6-7pm and 8-10pm. There is generally an increase in attendances from around 7am throughout the day, with a significant drop between 7pm and 8pm.

As a snapshot of the top five patients who most frequently attend, four out of five had some occasions where they attended more than once a day (range = 1-3). On average, these patients had around 12 days between each attendance (range= 1- 134).

Just under 70% of this group attended ED via the emergency services (e.g. SWAS), with 20% as walk up and the remaining 10% via primary care, police or 'other'.

c. Case note analysis

A detailed analysis of the top ten most frequent attenders identified that 100% had long term conditions. Six presented on at least one occasion with medically unexplained symptoms not associated with their medical condition. Half the group were taking at least two different prescription drugs, with some high levels of polypharmacy. Half the group were reported to have complex psychosocial needs, which included supported living arrangements, social services care packages or mental health services. Two were reported to have cognitive difficulties.

FAs often had incorrect addresses, or when contacted, appeared highly distressed and declined an appointment based on health or social reasons. This gave the impression that those who most frequently attended were living difficult lives that may be described as chaotic, e.g. debt problems, often moved/rehoused. This is consistent with the case notes of the top third.

Two patients identified as FAs and known to the hospital pain clinic were offered psychological interventions directed at assessing relevant factors in their frequent ED attendance, and developing appropriate strategies to better meet their needs. One patient presented with a pain complaint (case 1), the other a long-term condition (Case 2³²). It was evident from psychological assessment of these two cases that anxiety was playing a significant role in perpetuating attendance: neither patient found attending the ED a positive experience and were actively fearful of attendance, both appeared to delay attendance until perceived ‘crisis’ point (i.e. it is reasonable to have attended the GP much earlier rather than wait and attend the ED) and both experienced considerable psychological distress associated with catastrophic fears related to their health. Health anxiety is seen in up to 25% of medical clinics³¹, however this has not been explored in acute settings. The interventions offered consisted of a standard course of cognitive behaviour therapy for health anxiety³³ with medical consultant input to correct erroneous beliefs relating to pain management.

Business intelligence data demonstrates a reduction in costs to the NHS by approximately £13,300 (including outpatient appointments, ED attendance, inpatient stays) since commencement of treatment, the equivalent of one annum (2012/13 to 2013/14) (see table 1),

Insert table 1 here

Table 1: illustration of the reduction in costs for 2 patients in the year prior to and following a brief intervention

Estimated costs for therapeutic input (twelve one hour sessions plus supervision and preparation) are in the region of £1,000. This indicates savings in the region of £12,300 per annum if gains are maintained,

however this should be taken as a basic indication of the region of costs, rather than a full health economic costing

These two case studies reflect the potential benefit of psychological intervention to reduce costs to the NHS. Patient A³² has maintained these clinical gains, having not attended the ED since treatment in 2014.

d. Care plans

Four patient care plans were reviewed. These care plans were difficult to find within patient hard copy medical notes. They took the form of a paragraph outlining step-by-step treatment plans on attendance to the ED and featured at the foot of clinic letters. Typically, these care plans outlined exclusion of further tests, graded medication usage, and steps for prevention of admission. Also outlined were the circumstances in which the care plan should be followed. For example, the care plan may only relate to specific patient complaints such as abdominal pain. ED staff indicated that care plans lack consistency due to limited provision of specialist support to compose them.

The care plans reviewed were not easily accessible, infrequently used and in an unstandardized format with minimal information. Further information gathered from ED staff indicated that staff report not being able to locate care plans. There is a process currently in place to access care plans however this is evidently not known to all staff: care plans are uploaded electronically onto 'patient first', which will flag up when a patient attends. The ED secretary can scan care plans onto 'patient first' and add an alert.

2. Exploration of staff perceptions and attitudes

Staff Interviews

Three general themes emerged from the staff interviews:

Divided staff perceptions of FAs

Nurses and consultants were divided on their perception of FAs. Impressions ranged from compassionately believing the ED had failed this group, to considering the majority of FAs to be 'attention seeking' and acting with nefarious intentions or inappropriate help-seeking behaviour.

FAs were considered by staff to have complicated social circumstances, as well as psychological vulnerability (e.g. deficit in ability to reflect, poor problem solving, external locus of control, difficulty trusting others, tendency to catastrophise [sic]). They were considered to have high health anxiety, with inaccurate or unhelpful beliefs about illness and illness management. Illness beliefs and management

of health were also perceived to be moderated by the health beliefs of others, e.g. family. This was considered by pain clinicians to be influenced by genuine fear over health.

The ED was considered to represent the ‘end of a loop’, where patients have become highly distressed, expressing this in various forms before reaching crisis point at ED, with a quieter period to follow before the loop, or cycle, continues. ED may be just one point within that cycle.

The medical model: expectation and anxiety

An emphasis was placed on the observation that individuals attending the ED are operating within a medical culture- patients who present with ‘medical’ symptoms (like pain) expect ‘medical’ diagnoses and treatment. Pain clinicians indicated that the majority of ‘pain’ FAs present to ED with medically unexplained symptoms. Clinicians stated that they believed it to be a common misconception that these people were motivated by opioid use.

For medically unexplained symptoms it is common for serious illness to be ruled out by the ED and patients discharged without diagnosis. In the absence of identified underlying pathology, anxiety will be raised and patients dissatisfied. These anxious patients may become more ‘demanding’ [sic] and thus receive further medical investigation or intervention. If this (perhaps unnecessary) treatment is seen as appropriate and helpful by the patient this will reinforce the belief that attending the ED was ‘the right thing to do’, and they will likely repeat this reinforced behaviour the next time they experience symptoms that are unfamiliar or induce fear.

It was reported that a high proportion of attendances were associated with pain complaints. Staff voiced a common key concern: what if we discharge them too early (perhaps because they are FAs) and we have missed something? This indicated a ‘better safe than sorry’ culture and refers to the practice that, even with repeated attendances for the same complaint, a full investigation may be undertaken, especially in cases such as chest pain which can be both signs of malignant disease or panic/anxiety which is unpleasant but innocuous. Staff acknowledged that for serious symptoms like chest pain, patients are more likely to be brought to the ED by ambulance or accepted as ‘walk-ins’ because healthcare professionals don’t want to ‘miss something’ such as a myocardial infarction.

Inadequate provision

Clinicians stated that the needs of this group of patients were not being adequately met – many current solutions offer a ‘plaster for a deep wound’. It was acknowledged that more appropriate services were needed, underpinned by ‘firmer boundaries’ or generally ‘better care’.

Clinicians reported that the ED processes do not enable clinicians to easily access important and relevant background information, which should be taken into consideration when treating patients. Attendance frequency is rarely flagged unless a clinician recognises patients from previous visits, but lack of continuity of care often prevents this. In the ED each visit is likely to be attended by different clinicians, possibly resulting in provision of conflicting advice when relevant information is not accessible.

Care plans were recommended by clinicians; however staff expressed mixed views due to the reported inconsistency of implementation. It was suggested that care plans should be made in primary care, with specific conditions (discussed further in a later section).

Clinicians suggested that FAs are not a homogenous group and more likely to feature subgroups presenting with specific needs that set them apart. They highlighted the importance of distinguishing between groups of FAs, for example, alcohol versus non-alcohol related issues and those with elevated risk of frequent attendance due to palliative/end of life care issues.

Emphasis was placed on the important role of other health care agencies and how the essential pathway to and from the ED should be clearly defined. Clinicians indicated that frequent attendance should be considered a 'systemic' problem, not attributed to the patient or one sole service. There was an absence of unanimous agreement on whether there was a sufficiently clear pathway to pain services.

Discussion

The literature indicates that pain and frequent attendance at the ED symbolise complex unmet need, which warrants close attention to inform optimal healthcare pathways. This study aimed to better understand the characteristics and needs of patients who regularly attend this community acute district general hospital ED from a patient and staff perspective, and assess processes and procedures currently in place to address unmet needs, particularly in relation to pain with a view to producing a set of recommendations for change.

Case note analysis of FA records in the present study presents a picture of vulnerability and complex physical and social needs (mental health problems, forensic histories, poor social support, housing problems, lack of familial support). As anticipated from previous studies¹, it was clear that the majority of frequent attenders were experiencing heightened levels of pain that they interpreted as life threatening or in urgent need of intervention. Patients were well embedded within the medical system and anxious about their health needs not being met. Many patients had reason to feel anxious about their health, with history of familial sudden or serious illness, difficult relationships with health professionals and poorly

controlled long term conditions or pain. This is consistent with the body of literature indicating that this group of people are vulnerable and have pronounced and complex health needs, but are by no means a homogenous group⁵⁻⁷. While the majority of our findings echo those of other studies, it is noted that within this study, frequent attenders most commonly fell below the age of 40, which is discrepant with existent literature^{8,9,10} that report highest attendance in middle age category (with mean age of 48-49^{9,10}). This study also identified a fairly equal spread between males and females. These differences may be attributable to the differences in focus and scope of the aforementioned studies: the present study sought to describe a FA population and their unmet need by narrowing focus to the top 50 attenders, rather than broadening to include significantly higher sample sizes which compare frequent and non-frequent attenders; this study was commissioned to develop a set of recommendations to more adequately meet the needs of the FA in the target general district hospital ED, therefore findings are appropriate to the aims, however it is noted that these discrepancies in findings cannot be generalised to other ED and warrant further investigation.

All FA case notes analysed reflected vulnerability and suggested a deficit in the necessary skills to manage their health needs effectively. Such difficulties may well compromise their ability to engage with appropriate services or make reasoned decisions about their healthcare (which simply may not be a priority). The literature suggests that lack of understanding^{11-14,17} and heightened anxiety¹⁶⁻¹⁸, which appear evident in the case notes, are likely to influence help-seeking and often result in attendance at the ED.

Consistent with a previous study⁵ patients tended to lack a 'coherent' understanding of their condition and how to manage it. Perceived control was considered key in patients' decision making around their health and a sense of loss of control (especially in relation to pain) often precipitated a fearful, or panic, response. Patients reported that they would often defer or avoid accessing health care until problems had progressed; the fear of losing control and the anxiety around implication of further health complications were sufficient to endure symptoms until they had reached crisis point, when the ED was the only option. This behaviour is commonly seen in health anxiety³⁵ now known as illness anxiety³⁶ and appears to present prolifically in the FA population, however this is yet to be examined in emergency medicine.

Elevated concern expressed (or anxiety) by such FAs appeared to trigger to a domino effect of anxiety between staff and patient which consequently raised patient anxiety levels further, feeding back into a cycle of anxiety which staff report can influence their decision-making in visiting the ED 'better safe than sorry'). On this basis specialist consultants involved in one patients' usual care were invited to communicate clear and coherent information regarding the patients' presenting condition, including recommendations of appropriate self-care and self-management. This corrected erroneous illness

beliefs and offered more control and insight into the condition, with the patient reporting: “now I *know* I don’t need to come”. This proved to be a brief but powerful intervention, further illustrating a need for education around health problems. It presents a compelling argument for developing clear and well communicated information for patients who attend the ED, specifically relating to pain, self-management and appropriate use of health services. Research has indicated that provision of education and self-management information is a key strategy in successfully reducing frequent attendance²⁸⁻³⁰. Information and education should also be adapted to carers and families, as evidently patients are often motivated by the concern or influence of others¹².

It has been identified that the most successful intervention used to address unmet need and reduce frequent attendance within EDs is a case management approach, with or without the inclusion of multidisciplinary input^{8, 24-26}. However, these studies are mostly US-based. While no case management approach has been trialled in this hospital, ‘care plans’ have been utilised within the ED (which forms one component of this approach). Unfortunately, staff at this hospital agreed that care plans were not commonly used and where present, were inconsistently implemented. They were deemed difficult to access, with no standardised way to prepare, complete or store them for regular use. Care plans commonly took the form of addendums to letters in general medical notes. Given that care plans are deemed useful when successfully implemented, this should be considered further by EDs as this is likely to lead to improvements in multi-disciplinary pain management for all patients.

The cycle of frequent attendance demonstrates a poor fit between medical model emergency services and vulnerable patient groups with compromised psychological and social circumstances. Indeed, this ED, as with other NHS EDs is facing a national crisis. Without infrastructure to facilitate transition through appropriate pathways, it is inevitable that frequent attendance will continue as patients view the ED as an accessible service that treats health problems and alleviates health related anxiety.

Without the appropriate referral pathways indicated in the literature (e.g. for primary care input, and homogeneous urgent care clinics for pain, and specific chronic conditions^{8, 12, 25, 27}), patients will re-present at the ED with a perceived ‘medical emergency’, especially when there is a sense of ‘loss of control’^{5-6, 28}, or an expectation of receiving appropriate treatment. This was evident in our findings that staff reported current systems as ineffective at meeting the needs of FAs. This contributed to staff anxieties around missing something serious, and emphasised a ‘better safe than sorry’ mentality towards treatment (thus reinforcing a sense of need to attend ED when in pain).

The ED in this study has established a working relationship with the pain clinic, however there was not a formalised process and it is perceived to be inconsistently utilised. Engagement with primary care, mental health or other appropriate services should provide the patient with a more coherent

understanding of the problem, ways of managing it, and services that can help. This could potentially shift perception of the problem from a medical emergency to a ‘flare up’, precipitating more appropriate self-management.

The literature emphasises the importance of a multi-modal bio-psycho-social approach to improve the often inadequate treatment of pain in the ED²¹⁻²³. This project has established that traditional methods of rehabilitation (e.g. pain or chronic condition services) alone may be insufficient in meeting FA needs, as difficulties in engagement typify this group. With the proliferation of low intensity psychological therapies and CBT based groups now available on the NHS to individuals with long term conditions and those with pain³⁷, we can assume these services will offer new opportunities to engage individuals presenting at the ED. However, it is unlikely that such generic interventions will sustain permanent change for individuals with complex psychosocial backgrounds and physical health problems as seen in FAs.

The outcome of the clinical case studies reported here and recent data on a similar CBT-based pilot study within an ED³⁷ have both demonstrated marked reductions in clinical distress and cost to the NHS. This suggests improved outcomes can be affordably achieved for complex patients if appropriate targeted and tailored interventions are available. Although further work is needed to establish precise off-set costing for these interventions, a simplistic view of the data in this study suggests that long term reduction in attendance and admission is likely to lead to significant reduction in NHS costs.

Although this study is limited in its generalizability, given that our findings support and replicate previous findings, we tentatively suggest that our recommendations may be beneficial to all EDs. A service development study such as the one described in this paper may be comparatively limited in its lack of scientific rigour, however its exploratory nature provides a plausible basis for further research that employs more robust approaches that investigate the separate areas in more detail. Notwithstanding this, we believe this study offers an important and credible overarching examination of current culture and crisis within the ED.

Recommendations

Based on the findings of this report, there are a number of areas which would significantly benefit from change and improvement to better meet the needs of this population:

- *Frequent attender policy*

This is a simple intervention which would ensure a systematic approach to responding to the needs of patients while ensuring appropriate use of health services. A clear policy appropriate to clinical need would also discourage a 'better safe than sorry' culture. It is recommended that the frequent attender policy is developed in consultation with ED staff, management, psychology, pain clinicians and patient representative(s) to ensure a protocol appropriate to need. The continued implementation may be overseen by nursing staff assuming responsibility for frequent attenders. The frequent attender policy should cover the following aspects: care pathways, care plans, the use of screening tools and the provision of information/education. These will be defined further as follows.

- *Multi-faceted care pathways*

Individuals who do not self-harm have psychiatric problems or misuse substances do not receive tailored input, signposting or follow-up. Yet many of these are frequent attenders with unexplained symptoms, long term conditions or undetected mental health problems (e.g. anxiety/depression) who continue to use the ED as part of their own crisis self-management. A clear care pathway would increase the likelihood of better meeting clinical need and subsequently reduce inappropriate use of health services. This should be included within the frequent attender policy and draw out existent resources e.g. pain clinic, patient support groups, GPs.

- *Collaborative multi-disciplinary care plans*

Care plans appropriate to need, involving the patient (where appropriate) and easily available would invite a consistent approach to treating a patient who frequently attends. This would reassure, and ensure less distress on part of the patient and staff member. Care plans discourage a 'better safe than sorry' culture, and can form part of policy and pathway. Care plans should form part of the frequent attender policy. A clear line of responsibility for implementation is key, particularly in care plans which may feature multiple services or stages of intervention.

- *Staff support*

Promoting staff confidence in dealing with frequent attenders would benefit both staff and patients. Staff support should be multi-level, including the successful implementation of new policies or care pathways, basic level mental health screening training, consultation with psychology for more regular organised supervision to discuss particularly difficult or complex cases. With these interventions in place, it is likely that staff will be more confident and experience less stress in working with this group.

- *Screening tools*

Whilst the mental health liaison service is able to offer psychiatric evaluation, it may be useful if the ED has access to a battery of brief assessments which relate to psychological distress. This would inform care plans, care pathway referral and confidence in staff at screening for anxiety and depression which may be key factors in self-care and self-management. Brief measures are available and widely used within primary care settings, so it would be particularly helpful and facilitate good communication if questionnaires commonly used by GPs and national IAPT services (Improving Access to Psychological Therapies) were used in the ED.

- *Written information for patients*

A brief, simple and clear information leaflet should be developed to give to patients who present as accessing the ED when another service may have better met their needs. This should also be designed with carers and families in mind. An ED specifically designed leaflet may include all points of access and in what circumstances they would be used, and would essentially include contact numbers and addresses of relevant services.

- *Brief discharge action plans appropriate to presenting need*

This would state the discharge diagnosis, in what case the patient should return, and what services would be appropriate to this need.

To be successful, these recommendations would need to be implemented in a systematic way and include ‘joined up’ working with other relevant agencies such as GP out of hours, the pain clinic and mental health liaison where appropriate. Implementation is likely to lead to a reduction in health costs per patient, better relationships between patient and staff and also between health care agencies: better met need in every domain, fulfilling trust values.

Conclusion

This study indicates an absence of coherent approach to meeting the needs of FAs in the ED, and particularly those experiencing pain. The problem is likely to be of a systemic nature and a new overarching framework should be defined by the understanding that this group is vulnerable, complex

and presenting with genuine need (whether this be due to pain and/or health related anxieties). Pain related anxiety on the part of the patient and a 'better safe than sorry' culture within a medical setting like ED may influence the clinical decision-making process and should be investigated further. This can potentially result in inaccurately targeted treatments that are ineffective or unnecessary at best, and maintaining the problem at worst. Patients are re-presenting to the ED with the reinforced belief that they will be reassured about their pain, whether or not it was successfully treated on previous occasions.

The triangulated data reveals a consensus: patient need is not being met; the problem is systemic and unlikely to spontaneously resolve. Improvements in the quality and accessibility of individualised care plans, provision of patient education, psychological care and implementation of policies and procedures will improve the culture, staff satisfaction and staff relationships with this vulnerable group of patients, and likely result in a cost saving to the NHS.

Acknowledgements

The authors would like to extend their thanks to the ED and business intelligence staff and all patients involved in this study who participated in the study and also Dr Fiona Beech who was involved in the shaping of the study and original service level report.

Financial support

This study was financially supported by the commissioning hospital, Royal United Hospital NHS foundation trust, specifically financially supporting the lead author in terms of dedicated time to the project.

Ethical approval

Local R&D and ethical approval was not deemed necessary for this study as it was considered to be a service evaluation study in concordance with the NRES guidance (2009). No patient identifiable data is used, with summary data used throughout.

References

1. Todd KH, Ducharme J, Choiniere M, Crandall CS, Fosnocht DE, Homel P, Tanabe P, PEMI Study Group. Pain in the emergency department: results of the pain and emergency medicine initiative (PEMI) multicenter study. *The Journal of Pain*. 2007; 8(6): 460-466.
2. Berben SA, Mejis TH, van Dongen RT, van Vugt AB, Vloet LC, Minjes-de Groot JJ, van Achterberg T. Pain prevalence and pain relief in trauma patients in the Accident & Emergency Department. *Injury*. 2008; 39(5): 578-585.
3. Ducharme J, Barber C. A prospective blinded study on emergency pain assessment and therapy. *The Journal of Emergency Medicine*. 1995; 13(4): 571-575.
4. Karwowski-Soulié F, Lessenot-Tcherny S, Lamarche-Vadel A, Bineau S, Ginsburg C, Meyniard O, Mendoza B, Fodella P, Vidal-Trecan G, Brunet F. Pain in an emergency department: an audit. *European Journal of Emergency Medicine*. 2006; 13(4): 218-224.
5. Olsson M, Hansagi H. Repeated use of the emergency department: qualitative study of the patient's perspective. *Emergency Medicine Journal*. 2001; 18(6): 430-434.
6. Byrne M, William Murphy A, Plunkett PK, McGee HM, Murray A, Bury G. Frequent Attenders to an Emergency Department: A Study of Primary Health Care Use, Medical Profile, and Psychosocial Characteristics. *Annals of Emergency Medicine*. 2003; 41(3): 309-318.
7. Sun BC, Burstin HR, Brennan TA. Predictors and outcomes of frequent emergency department users. *Academic Emergency Medicine*. 2003; 10(4): 320-328.
8. Pines JM, Asplin BR, Kaji AH, Lowe RA, Magid DJ, Raven M, ... & Yealy DM (2011). Frequent

users of emergency department services: gaps in knowledge and a proposed research agenda. *Academic Emergency Medicine*, 18(6), e66-e69

9. Kirby SE, Dennis SM, Jayasinghe UW, Harris MF. Frequent emergency attenders: is there a better way? *Australian Health Review*. 2011; 35(4): 462-467.

10. Jelinek GA, Moyez J, Gibson NP, Lynch A-M. Frequent attenders at emergency departments: a linked-data population study of adult patients. *The Medical Journal of Australia*. 2008; 189(10): 552.

11. Murphy AW. 'Inappropriate' attenders at accident and emergency departments I: definitions, incidence and reasons for attendance. *The Journal of Family Practice*. 1998; 15(1): 23-32.

12. Penson R, Coleman P, Mason S, Nicholl J. Why do patients with minor or moderate conditions that could be managed in other settings attend the Emergency Department? *Emergency Medicine Journal: EMJ*. 2012; 29(6): 487-491.

13. Rajpar SF, Smith MA, Cooke MW. Study of choice between accident and emergency departments and general practice centres for out of hours primary care problems. *Journal of Accident and Emergency Medicine*. 2000; 17(1): 18-21.

14. Gill JM, Mainous AG 3rd, Nsereko M. The effect of continuity of care on emergency use. *Archives of Family Medicine*. 2000; 9(4): 333.

15. Gutherz C, Baron S. Why Patients with Primary Care Physicians Use the Emergency Department for Non-urgent Care. *The Einstein Quarterly Journal of Biology and Medicine*. 2001; 18: 171-176.

16. Adamson J, Ben-Schlomo Y, Chaturvedi N, Donovan J. Exploring the impact of patient's views on 'appropriate' use of services and help seeking: a mixed methods study. *British Journal of General Practice*. 2009; 59(564): e226-e233.

17. Padgett DK, Brodsky B. Psychosocial factors influencing non-urgent use of the emergency room: a review of the literature and recommendations for research and improved service delivery. *Social Science and Medicine*. 1992; 35(9): 1189-1197.
18. Rieffe C, Oosterveld P, Wijkkel D, Wiefferink C. Reasons why patients bypass their GP to visit a hospital emergency department. *Accident and Emergency Nursing*. 1999; 7(4): 217-225.
19. Unger-Saldana K, Infante-Castaneda CB. Breast cancer delay: a grounded model of help seeking behaviour. *Social Science and Medicine*. 2011; 72(7): 1096-1104.
20. Cornally N, McCarthy G. Help-seeking behaviour: a concept analysis. *International Journal of Nursing Practice*. 2011; 17(3): 280-288.
21. Fosnocht DE, Chapman RR, Swanson ER, Donaldson GW. Correlation of change in visual analogue scale with pain relief in the ED. *American Journal of Emergency Medicine*. 2005; 23(1): 55-59.
22. Wilsey BL, Fishman SM, Ogden C, Tsodikov A, Bertakis KD. Chronic Pain Management in the Emergency Department: A Survey of Attitudes and Beliefs. *Pain Medicine*. 2008; 9(8): 1073-1080.
23. Khan KA, Weisman SJ. Nonpharmacologic Pain Management Strategies in the Pediatric Emergency Department. *Clinical Pediatric Emergency Medicine*. 2007; 8(4): 240-247.
24. Skinner J, Carter L, Haxton C. Case management of patients who frequently present to a Scottish emergency department. *Emergency Medicine Journal*. 2009; 26(2): 103-105.
25. Pillow MT, Doctor S, Brown S, Carter K, Mulliken R. An emergency department-initiated, web-based, multidisciplinary approach to decreasing emergency department visits by the top frequent

visitors using patient care plans. *Journal of Emergency Medicine*. 2013; 44(4): 853-860.

26. Helliwell PE, Hider PN, Argagh MW. Frequent attenders at Christchurch hospital's emergency department. *New Zealand Medical Journal*. 2001;114(1129): 160-161.

27. Coleman EA, Eilertsen TB, Kramer, AM, Magid DJ, Beck A, Conner D. Reducing emergency visits in older adults with chronic illness. A randomized, controlled trial of group visits. *Effective Clinical Practice*. 2001;4(2): 49-57.

28. Grimmer-Somers K, Johnston K, Somers E, Luker J, Alemao LA, Jones D. A holistic client-centred program for vulnerable frequent hospital attenders: cost efficiencies and changed practices. *Australian & New Zealand Journal of Public Health*. 2010; 34(6): 609-612.

29. Michelen W, Martinez J, Lee A, Wheeler DP. Reducing frequent flyer emergency department visits *Journal of Health Care For the Poor & Underserved*. 2006; 17(1): 59-69.

30. Wan PW, Boh C, Xin X, Chay CJC, Choong HL, Mooppil N, Yeo RSL, Pasupathi Y, Ong MEH. Reducing frequent attendance by chronic kidney disease patients at the emergency department. *Academic Emergency Medicine*. 2013; 20: S231.

31. Tyrer P, Cooper S, Crawford M, Dupont S, Green J, Murphy D, Salkovskis P, Smith G, Wang D, Bhogal S, Keeling M, Loebener G, Seivewright R, Walker G, Cooper F, Evered R, Kings S, Kramo K, McNulty A, Nagar J, Reid S, Sanatinia R, Sinclair J, Trevor D, Watson C, Tyler H. Prevalance of health anxiety problems in medical clinics *Journal of Psychosomatic Research*. 2011; 71(6): 392-394.

32. Daniels, J Sheils, E. A complex interplay: cognitive behavioural therapy for severe health anxiety in Addisons's Disease to reduce Emergency Department admissions. *Behavioural and Cognitive Psychotherapy*. 2017 Apr: 1-8.

33. Tyrer P, Cooper S, Salkovskis P, Tyrer H, Crawford M, Byford S, Dupont S, Finnis S, Green J, McLaren E, Murphy D. Clinical and cost-effectiveness of cognitive behaviour therapy for health anxiety in medical patients: a multicentre randomised controlled trial. *The Lancet*. 2014; 383(9913): 219-225.
34. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (5th ed)*. Washington, DC: American Psychiatric Publishing 2000.
35. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (5th ed)*. Arlington, VA: American Psychiatric Publishing 2013.
36. Department of Health (2011). *Talking Therapies: a four-year plan of action*. Accessed from: <https://www.gov.uk/.../talking-therapies-a-4-year-plan-of-action>. Retrieved 15th October 2016.
37. Baker M, Stallard J, Gibson S. A pilot project targeting frequent attenders at the emergency department with medically unexplained symptoms. *Emergency Medicine Journal*. 2013; 30(10): 866-866.